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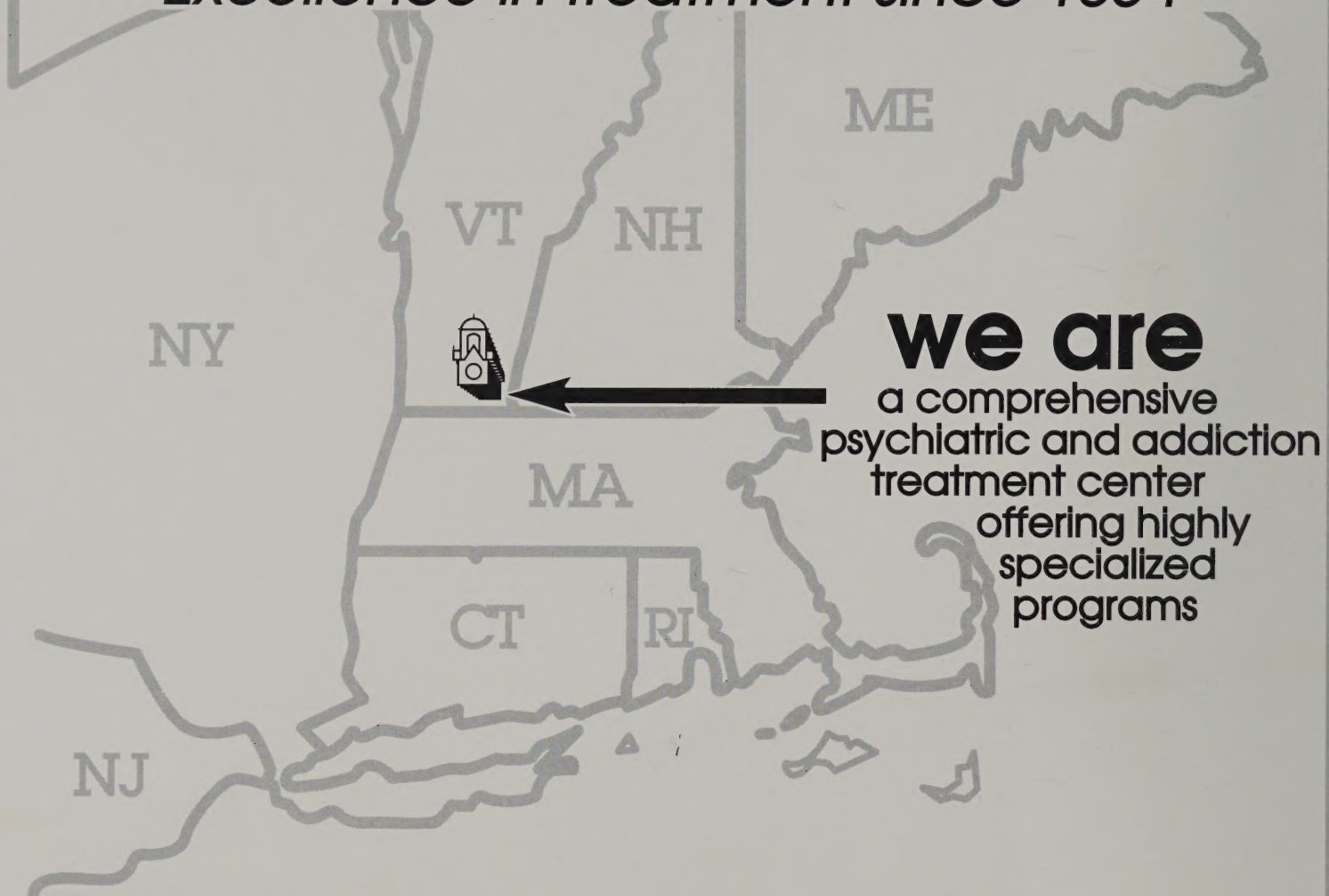

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THE HAMPDEN HIPPOCRAT
NOVEMBER-DECEMBER 1990
VOLUME XXXXV NO. 11

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On our cover is the Wing Memorial Hospital in Palmer, Massachusetts. See related article on page 8 in this issue.

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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H. Bernard Tillman, M.D. 1909-1990

EDITOR'S NOTE: *This memorial tribute to Dr. H. Bernard Tillman was written by his friend, Dr. Louis A. Izenstein.*

Dr. H. Bernard Tillman was born in Springfield. He graduated from Central High School, received the degree of Bachelor of Arts from Brown University and the degree of Doctor of Medicine from Cornell University School of Medicine. He Interned at the Montefiore Hospital at Bellevue Hospital in New York and at the Springfield Hospital, now part of the Baystate Medical Center. He entered the private practice of Medicine in Springfield in 1937. He was the founder of the Allergy Clinic at the hospital and served as Director of the Allergy Service until he retired from active practice in 1987.

He was a fellow of the American College of allergists and was honored with an Award of Merit by the College in 1981. He was a member of the American Association of Clinical Immunology and Allergy and served as President of its Northeast Region.

He was a very active member of the Hampden District Medical Society and of the Massachusetts Medical Society. He served with distinction as Chairman of the important Insurance Committee for over 20 years. He was a member of the State Society Insurance Committee as well. He was a Counselor to the Mass Medical Society from 1960-1972. He served as a Censor for the State Society for five years. In addition, he found the time, energy, interest and ability to serve as Assistant and Associate Editor of the Hampden Hippocrat from 1959 to 1973. During these latter years he served with distinction with the late Dr. Max Millman. The combination team of Millman and Tillman helped greatly in the growth and development of the Hippocrat to its current status.

In addition to these activities in and for Organized Medicine, Dr. Tillman served as Vice President of the Kodimoh Synagogue, where he worshipped regularly. He was also a member of the Board of Directors of the United Hebrew School. Close to his heart was the Maimonedes Medical Club where he served as President and as Secretary for many years. To have heard his Annual Reports was a special treat reserved for the Chosen Few. His Annual Reports were Models of accurate reporting, embellished with words of Wisdom, Philosophy, and Ethical Values. He was an authority on Robert's Rules of Parliamentary Procedures and was able to quote Chapter and Verse to substantiate his decisions.

But more significant than the above, Dr. Tillman was a Man of Peace. Never was his voice raised in anger. He was a True disciple of Aaron the High Priest—loving Peace, pursuing Peace, and bringing Peace to his fellow man, particularly to those in distress under his capable professional care.

He was able to desensitize the negative disturbing elements of his patients' illnesses, to bring to them greater Peace of Mind and Body.

To his wife and children we express our deep sympathy. They provided him with Peace. He is sadly missed by his many patients and friends. ■

Louis A. Izenstein, M.D.

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From The MMS Regional Office

The strength of the Massachusetts Medical Society (MMS) is derived from the unified voice of its 14,300 members. As the oldest, continuously operating state medical society in the United States, the MMS represents the Commonwealth's medical profession, and is dedicated to serving its physician members and their patients.

As one of the 14,300 members currently represented by the Society, you recognize the importance of working together to achieve common goals. However, some 500 of your colleagues in the Greater Springfield area have yet to join the Society and to lend their support to the work being done on behalf of the profession.

Recruitment is the vital link to the endurance of our organization. For the MMS to prosper we must attract and retain members. We must perservere until the day that one hundred percent of Massachusetts physicians can proclaim to be members of the Massachusetts Medical Society.

The **RECRUITMENT OF COLLEAGUES CAMPAIGN** needs your help. By far, the most successful membership drive is a peer-to-peer effort, members recruiting their colleagues. To this end, the MMS Membership Department has designed a "user friendly" way for you to recruit nonmember physicians.

Upon signing up as a program participant, you will receive a Recruitment Kit that includes membership applications, support materials, and a list of nonmembers by district, medical specialty, gender, medical school faculty or hospital affiliation. A MMS staff member will act as a liaison to you throughout the campaign, to offer support and advice. The program begins October 1, 1990 and will continue through May 1, 1991.

Participants who recruit six or more new members will be recognized at a special ceremony during the MMS Annual Meeting and awarded a wool blazer from Burberry's of London. Each blazer will have a detachable MMS logo on the breast pocket. Members who recruit at least one new member will receive a Burberry's of London wool scarf, also to be presented at the MMS Annual Meeting.

To become part of the **RECRUIT YOUR COLLEAGUES CAMPAIGN**, of if you would like additional information, please contact the MMS Department of Membership Services at 1-800/322-2303. For over 200 years the Massachusetts Medical Society and its members have served as a powerful advocate for physicians. Your assistance with the **RECRUIT YOUR COLLEAGUES CAMPAIGN** will help keep the MMS in the forefront of health care delivery in the future. ■

Kerin L. Milesky,
Regional Office Coordinator

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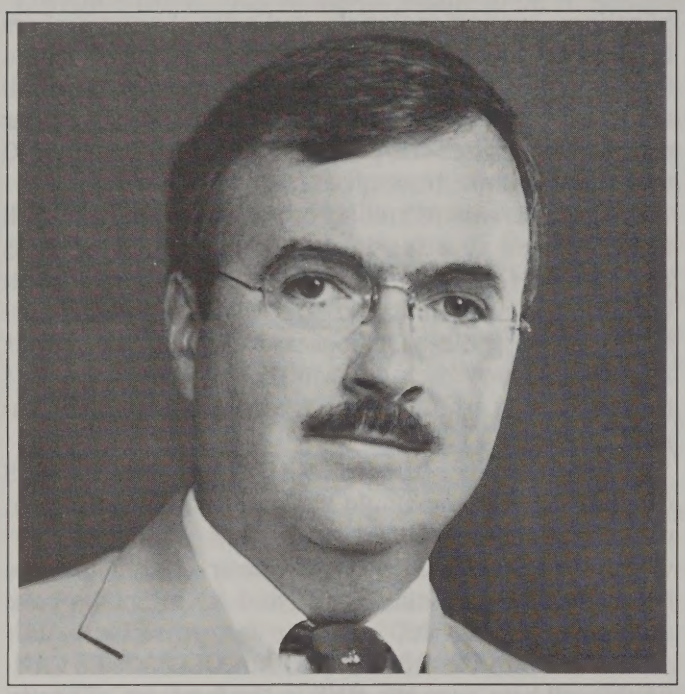
HDMS President's Message



Joseph P. Keenan, M.D., President

The HDMS has many interesting programs and initiatives planned for the coming year. I would invite each and every member to become more involved with the activities of the HDMS. Our society will be strengthened and enriched by your participation. If an issue is omitted that you think needs to be addressed by the HDMS, please call me, or better yet, come to the monthly Executive Committee meeting and bring your ideas.

After a recent conversation with Sheriff Michael Ashe, it is apparent that there is a tremendous need for additional health services for the residents of the York Street Jail. I am certain everyone is aware of the problem with overcrowding at the current facility and the armory "take over" that occurred earlier this year. There is a similar problem with a lack of medical services available to the jail residents. Sheriff Ashe and myself will be meeting next month to discuss ways that the HDMS might be of service in helping with this societal problem.

Drug and alcohol abuse are two of the major problems faced by our youth. The direct and indirect cost of the abuse is truly staggering to our society, both in terms of economic as well as personal loss. In response to this, the American Medical Association, in cooperation with the American Bar Association, has developed a program to help combat this problem. The Executive Committee of the HDMS at the urging of the Massachusetts Medical Society has endorsed this program and requests interested physicians and volunteers to participate in this program. As envisioned in this program—physician/attorney teams using the materials provided, will visit schools, educate, as well as serve as positive role models for the students. This program has also been endorsed by the Hampden County Bar Association and we look forward to working with them for the betterment of our community.

A Legislative breakfast is being planned for the fall, after the state election. There will be many new faces in state government and the Massachusetts Medical Society wishes to organize the physicians of Massachusetts and help them to become more effective when dealing with our elected leaders. We physicians have been very naive about political bureaucracy in the past and although this is changing we have a long way to go. All the local Representatives and Senators will be invited to the breakfast, which will be run by the Legislative Affairs Committee of the HDMS. All members of our society will be invited. A showing of 100 physicians at the meeting would be the strongest message we could give. A cordial working relationship must be forged with our elected leaders if we are going to have legislative success in the future.

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The Massachusetts PRO (Peer Review Organization) is a company owned and sponsored by the Massachusetts Medical Society. I am surprised by the number of physicians who are not knowledgeable of this fact. The Executive Committee of the HDMS is in receipt of an increasing number of complaints concerning the incompetency of the various reviewers and what is perceived as "harassment" of certain physicians. I understand that Baystate Medical Center has hired a physician to aid in the rebuttals of the alleged "quality issues" that are discovered by the Mass PRO reviewers. The Executive Committee of the HDMS plans to meet with Peter Maselli, M.D., Medical Director of the PRO, to discuss some of the issues with him. I would ask any member of the HDMS who feels that they have been unfairly treated by the PRO to contact me. Hopefully, the HDMS can serve as a clearinghouse for the complaints.

I have appointed Frank Horrigan, M.D. as chairman of the ad hoc Committee to develop a Mission Statement for the HDMS. A separate but related task will be to evaluate the performances of the HDMS. Some of the questions I have asked him to discuss are:

What are we doing?
What should we be doing?
How well are we doing it?

The committee will expire by year's end. Hopefully, as a result of this committee, we will have some valuable insight concerning our performances as an organization. An organization that does not meet the needs of its members becomes a lifeless, empty shell. Please contact me if you will volunteer for the committee. The only requirement would be to attend 2-3 evening meetings and an interest to make the HDMS more relevant to the needs of its physician members.

We have an exciting year ahead, and many ways for each individual member to become more involved. This is your organization. If you have any ideas or suggestions please contact me. ■

ACKNOWLEDGMENT

Dennis R. Anti, an attorney with Keyes and Donnellan, PC was the author of the article "Physician-Patient Confidentiality" in the last issue and his welcome contribution was inadvertently not recognized.

The Editors

To All Members

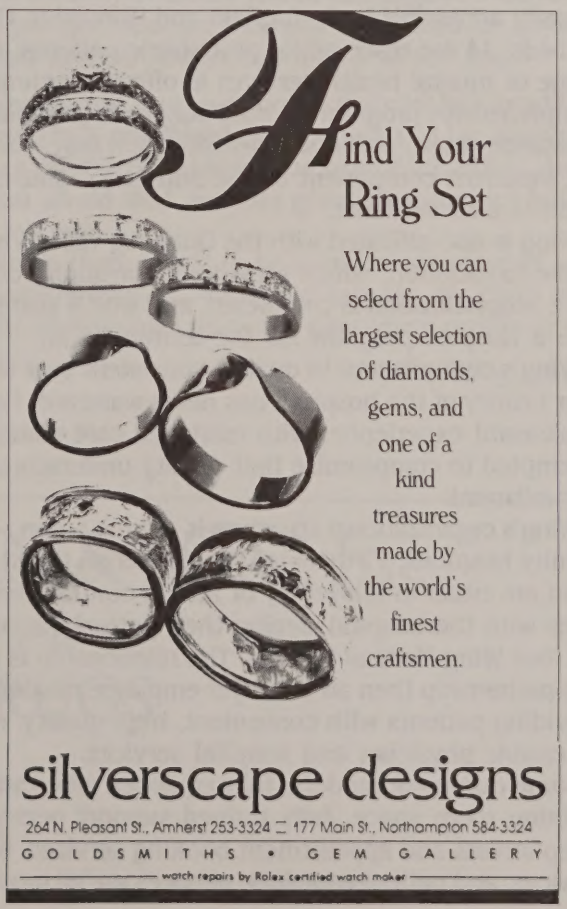
It has come to our attention that area women are being called in the evening by a man who says he is a physician working for the Center for Disease Control in Atlanta, Georgia. He sounds very official until he begins asking them very personal questions and it is obvious that the call is not legitimate.

If any of our physicians have had reports from their patients of phone calls such as this, they should tell the patient to try to remember:

1. if a name was mentioned
2. the nature of the questions
3. the exact amount of time they were on the line
4. the date and time of the call

If you know of such an incident, would you please call the Hampden District Medical Society's office at 736-0661 and let us know. We are trying to keep a record of these calls.

Thank you. ■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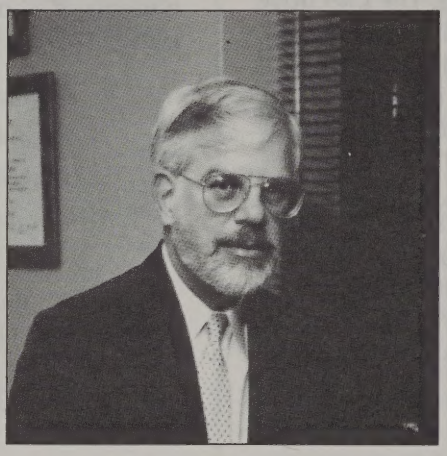
Wing Memorial Hospital

This is the eleventh in a continuing series of articles featuring Western Massachusetts Hospitals

PALMER—Recently, Richard H. Scheffer, president of Wing Memorial Hospital and Medical Centers received a letter from Dennis O'Leary, M.D., President of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) stating that Wing had scored among the top 10% of hospitals surveyed across the country. The Joint Commission team of six surveyors had visited Wing in March, inspecting the hospital, the four Medical Centers in Palmer, Monson, Wilbraham, and Belchertown, and the Griswold Center, Wing's outpatient mental health and substance abuse facility. There were no Type I recommendations. As a matter of fact, the surveyors asked for copies of Wing's policies and forms so they could use them as examples when they survey other hospitals.



Richard H. Scheffer,
President of Wing Memorial Hospital

Wing Memorial Hospital is a 70 bed, acute care hospital, whose close proximity to Exit 8 of the Massachusetts Turnpike makes it easily accessible to Springfield and Worcester. Of the 70 beds, 14 are reserved for psychiatric patients. A full range of mental health services is offered, including a comprehensive program for dual diagnosis (psychiatric/substance abuse) patients. A detoxification unit providing the inpatient component of the substance abuse program is also available.

Wing is also affiliated with the Quaboag Valley Visiting Nurse Association, which provides a continuity of care once hospitalization is completed, and which also sponsors a Hospice program for the terminally ill.

Wing's commitment to quality, consistent over the 76 year history of the hospital, has never waivered. Recent unpleasant experiences with managed care plans that attempted to compromise that quality underscore that commitment.

Wing's organizational structure is unique among community hospitals. Virtually all physicians on the staff of Wing are either employed by or have a contract for services with the hospital, seeing their patients in one of the four Wing Medical Centers. The relationship is more of a partnership then an employer-employee relationship, providing patients with convenient, high quality, easily accessible physician and hospital services.

Some examples: modern, fully equipped office and examining room space, fully trained support personnel, receptionists and appointment booking services, billing services, and patient education services are all provided. In addition, medical records can be dictated, and patients have only one medical record which travels with them throughout the system, so that the physician has, each time he or she sees a patient, the complete medical file with which to work.

Wing's support services are also exceptional. The Laboratory is CAP accredited, making it one of the 20% of hospital laboratories in the country with this distinction. Emergency Service personnel are trauma specialists. There is a helipad in close proximity to Wing's Emergency Room, and Lifeflight based at UMass. Worcester and Lifestar in Hartford provide air ambulance services.

The Cancer Program is accredited by the American College of Surgeons, and the Continuing Medical Education Program is accredited by the Massachusetts Medical Society for Category I programs.

A unique communication system includes facsimile (FAX) machines in all strategic areas of the organization for instantaneous transmission of data from one department to another, or back and forth from the satellite offices. A courier service shuttles supplies, lab samples, reports, et cetera throughout the system, making several trips to each every work day.

Modern technology is no stranger here. Some of the more recent acquisitions have been a full body CT Scan, low-dose mammography unit, a complete Biodex system in the Rehabilitation Services department, and nuclear cardiology studies instrumentation.

As impressive as the state-of-the art equipment is, however, it is still the dedication and commitment of the staff that has brought Wing into the "top 10".

People entering the hospital or one of the centers for the first time sense quality the moment they walk through the door. The facilities are clean—exceptionally clean, modern, and well appointed. The receptionists are courteous and helpful. Clear signage throughout the hospital points out the various services.

The medical and nursing staffs enjoy a true collegial working relationship. There is a spirit of cooperation and fellowship between employees and between departments that is tangible. There is no aristocracy among the staff, from administration on down the line. The most important people at Wing are, by far, the patients, and it shows. ■

Another View on National Health Care Systems: *The Hippocrat Interview*

Editors Note: Jeff Scavron, M.D., Medical Director of the Brightwood Neighborhood Health Center in Springfield, is a founding member and past national president of Physicians for a National Health Program (PNHP). This group advocates the adoption of a comprehensive health insurance program modeled on the Canadian system.

Q: How did you become involved in the founding of PNHP?

A: In 1986 there was a nonbinding resolution on the Massachusetts ballot urging Congress to work for a national health insurance program. It was sponsored by the Grey Panthers. The Grey Panthers contacted several doctors (including myself) who had worked with them in the past to solicit physician support for the referendum. They were worried that organized medicine wouldn't support even this general proposal. The referendum passed eventually by a two-thirds majority.

Meanwhile, in the summer of 1986 there was a weekend conference in New Hampshire of about two hundred pysicians from the Northeast who were interested in health care reform. Many of those who attended were involved in health care for the poor at neighborhood health centers or in county hospitals. At that conference, PNHP was formed. We felt that the problems involved in delivering health care, and not just for the poor, were getting out of hand and we thought the time was right to revive the efforts that some had started in the late 1970s.

Q: Why do you think that problems with access to care are increasing?

A: We've had Medicaid to take care of the poorest people since 1965. As health care costs have skyrocketed, more and more people have been unable to get health insurance through their jobs and unable to afford to buy it on their own. So, now, thirty seven million people don't have health insurance. There's another large group of people—maybe twenty million—who are underinsured. Overwhelming medical expenses are the commonest cause of bankruptcy. The underinsured would be wiped out if they were sick for any period of time. So that leaves sixty million people—that's one quarter of the U.S. population—who are either uninsured or underinsured.

Q: And that leaves out the problems with access for the poor under Medicaid?

A: The Massachusetts Medicaid program is—for the patient—a fairly good insurance policy. But in Alabama, if your make more than $1400 per year for a family of three, you're not eligible. Meanwhile, if you get Medicaid they pay five dollars for an office visit and no doctor can afford to see you.

Q: Why do you want a *national* system? In Canada the system is organized by province and the provinces are relatively autonomous from each other. Aren't you afraid that another giant bureaucracy will be created?

A: Where there needs to be a federal standard of what comprehensive care would include. We can't allow the dichotomies that exist now where certain groups

continued

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Another View on National Health Care Systems: *The Hippocrat Interview* continued

are allowed a level of care based on their insurance coverage or lack of it. The businessman who stays in a hotel three nights a week and the man who cleans the room need the same standard of health care. They may not have or need the same kind of car or clothes, but they need the same basic standard of care.

Still there would have to be organization of the system by region or by state with autonomy. The differences between health care needs in urban versus rural areas, for example, whould have to be recognized.

We're not talking about nationalizing hospitals or making all physicians government employees. The only thing that becomes public in our proposal is payment. We're not talking about a public system—England has a public system—and a parallel private system. In our proposal, doctors still work fee for service or capitation or are on salary. Hospitals are private non-profit institutions. There would obviously be less of a role for private non-profit institutions. There would obviously be less of a role for private for-profit hospitals.

Q: What's the difference between your group's proposal and what's been passed in the state of Hawaii?

A: The differences are that (in Hawaii) people can buy additional insurance—and the big difference is that the unemployed are not included. So there's a huge gap between the two groups. Also, a system for the employed that uses the conventional types of cost controls is incredibly expensive.

Q: In Canada, are the controls on hospitals similar to those that have been imposed on hospitals in Massachusetts?

A: The Canadian hospitals have an operating budget that is negotiated with a national health planning board annually. The budget is based on the patients that are seen and the costs of operating the hospital—not capital expenditures. Then the hospital receives one twelfth of their budget every month. The patients don't get these long itemized bills that go from one insurance company to the other and back to the hospital. The example is that there are more than two hundred people working in the billing department of the Massachusetts General Hospital with an enormously high priced computer system. This compares to the two people at the Toronto General Hospital with a PC who try to get the bills out to the people from the U.S. who were treated while visiting from across the border.

Q: How can the system that you're proposing be financed at a time when no one wants to spend any more money on health care?

A: Through decreasing the administrative overhead of the system. Our health care bill in 1989 was about $600 billion. Twenty three percent of that went towards administration of the health care system. In Canada, their administrative bill was thirteen percent and everyone had access to the system. If we could cut our administrative costs that ten percent, we would save $60 billion dollars a year. The Pepper Commission and the AMA say that that's the amount of money that we need to insure the uninsured.

We will still have to halt the rise in the cost of care. Before 1970 the percentage of the GNP that was devoted to health care costs was the same for the U.S. and Canada. After Canada put the current system in place, the curves diverged with the U.S. spending 12% most currently and Canada only 8.5%. Even allowing for differences in the rate of rise of the GNP itself between the two countries in various years that's a big difference.

Q: So do you think there's administrative waste in the current system?

A: Look at what's happening in our local medical center—there's a proliferation of administrators far in excess of the growth in the number of physicians. When they try to put cost controls on the system that we have now they come up with DRGs. They found that wasn't too good so then they developed PROs. Now they are going to have PROs, to review the PROs. There's a 7 billion industry of firms that are reviewing and overseeing the contracts that larger employers make with health insurance companies. Every doctor that I know is sick and tired of having the accountant sit in the examining room with them and the patient. Physicians are spending up to 30% of every hour on administration. Forty five percent of their employees' time is spent on billing.

Q: How else can the system be made more productive and economical?

A: After you save the money on the administrative costs, your regional health board does health planning

for the growth in the system. Growth in the system here is based more and more on the marketing and selling of care. The local hospitals compete with each other to supply the same services even when the services are not used at any point near capacity and the capital costs of having duplicated services are high.

Having regional health planning puts the considerations in developing new services on a medical basis and takes away the economic emphasis and "dampens" the entrepreneurial spirit. It certainly doesn't take it away as Canadians will be glad to tell you. The income of physicians in Canada is at five times the industrial wage.

Q: Do you think copayments are needed to prevent so called frivolous visits to the doctor?

A: A copayment stops some frivolous visits, but the next thing it does is to stop some non-frivolous visits. The third thing it does is to set up another adminstrative structure—you have to figue out how to collect it and what to do with it. I don't think it's worth it. You can change the average income of the person who's making the frivoulous visits with copayments, but you don't necessarily change the total number of frivolous visits.

Q: The recent leadership of the Massachusetts Medical Society has felt that as we evolve toward some form of a national payment system that the Society can play a key role in mediation between different specialties. Do you see that happening?

A: The Medical Society may well be the broker for the doctors, but the Medical Society will be the ones who can be the authorities for the region on the health care needs of the community. They will then get themselves back on the same side as the patients. Now the Medical Society is perceived as a self-serving special interest group by the public. We've lost a lot of respect because of that. We need to turn that around and become the proponents of good health care.

Brigid K. Glackin, M.D.

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The Changing Status of Society in North America

EDITOR'S NOTE: *In the last issue an address by Dr. Martin Barkin, Deputy Minister of Health in Ontario, was presented to the readers. This essay is a response from Dr. Gregory Slachta.*

Dr. Martin Barkin, Deputy Minister of Health of the Province of Ontario, wrote on the changing status of physicians in America and Canada in the previous issue of the *Hippocrat*. Although Canada and the United States share the same continent, we have differences in our democracies and our health care systems. We do, however, share similar values and ethics as societies and within our respective medical professions. Although "times they are a-changing", the assumption that it is necessary to therefore adjust to these influences is perilous; true statesmanship requires the ability to adjust, but also the ability to say no when there is clearly an error.

First, I agree that the deterioration is related in large part to third-party payors as Martin suggests. The reams of red tape, the growing liability crisis, managed care, professional review processes, and experimental reimbursement reforms complicate the delivery of care. However, I believe all of this is but a symptom of real disease. The real disease is the deterioration of the American strength known as "work ethic" or "self-reliance." The physician community continues its tradition of hard work and long hours in responsible care for our patients. The frustration and disappointment is toward government's response to the real problems facing American societies.

Americans have a nostalgia for a Marcus Welby era with a Star Trek technology at 1950 prices. In our modern societies, we have problems of poverty, abounding, drugs tearing at the fabric of youth, and a failing educational system. In the United States we have a Wall Street philosophy of short term gain with no long term commitment to industrial growth. Our work ethic is on the critical care list. We have a lottery mentality for the quick fix and no responsibility for our own well being. As a society we eat, drink, and smoke too much, and drive too fast. We pollute the water and the air. Our sexual lifestyles have led to an incurable disease. When our lifestyle puts us in the intensive care unit, we want to know why medicine has failed us, not what we could have done to prevent it. Our societies have not prioritized the new technology for improved longevity either in terms of funding or in terms of necessity.

Up to this point, Martin and I do not substantially disagree in our assessment of the problem. Where we part company is in terms of our respective prescriptions for health care in our societies.

Martin states that American-style health care makes us less competitive in world markets. Yes, we are less competitive than Japan. But it is not because of the $500 cost of every American car going towards health care. It has to do with productivity, lack of computerized technology, and other management and labor costs. In a free market the consumer will pay for quality and the Japanese have proven they can provide it. If their health care component is less, this is perhaps due to their life style and their differing expectations of health care.

On evaluating the Ontario experience of increasing costs, Martin believes increased volume and number of physicians are the cause. Increased volume and increased numbers of physicians reflect increased utilization of patients, however. If doctors are available, patients have access. Physicians do not usually create disease, but by availability and technology, can create demand. Martin mentions that the rate of new physicians entering practice in Ontario is five times the rate of increase in the population. This may be accurate but not material unless one factors in the aging population and its voracious appetite for health care. Authors such as Schwartz have suggested that there may be a physician shortage in the near future. Increases in cardiovascular services of 130% in three years reflects patient demand as well as physician availability, as long as rationing based on rigid criteria of the payor or acceptance of mortality on the part of the patient does not exist.

Martin criticizes the United States health system because of its highest per capita spending, its incompleteness, and its sporadic provision of care. The last two issues are not necessarily valid. Surely there is incomplete access to the U.S. system; some because of the complexity of entering the system; some by choice (who do not choose to purchase insurance); and some because they don't test the availability. But which is less complete—this system or a system in which rationing is by capitation of technology? Waits can be three months for a VCUG in Toronto and 18 months for a ureteroneocystostomy under a "universal coverage" system. As for the distribution of health care, whether it is any different in rural Canada and the rural United States is little more than opinion.

As for the high per capita cost of health care, I quote Michael Walken, Executive Director of the Fraser Institute in Vancouver:

"In 1965, Canada and the United States each spent 6.1 percent of their Gross Nation Products on health care. The 8.5% of GNP that Canada now spends on health care has been at that level since 1978. By contrast, total public and private spending on health care in the United States is over 11% of GNP."

This difference in spending has led many lawmakers in the United States to draw two conclusions. First, Canada's health care system is working well and is a model for the United States. Second, rapidly rising U.S. health care costs indicate that free markets are an inferior way to deliver health care.

A close examination of Canada's system shows that these conclusions are unfounded.

One problem with simple comparisons is that broad levels of spending are a poor barometer of performance.

Why is it desirable to spend a low fraction of GNP on health care? High fractions of GNP devoted to housing, recreation and travel are taken as signs of affluence and quality. Why not health care? A low fraction could be viewed with alarm, not satisfaction. Indeed, one perennial concern in Canada is the low fraction of GNP spent on scientific research and development. Similar concerns are raised about the level of educational spending in the United States.

When the enormous amount of money spent on health care is discussed, it seems exorbitant. But when comparing this sum with the 150 billion dollars Americans gamble annually, or the 256 billion dollars spent on dining out, or the 8 billion dollars spent on video movies, the figures are less impressive. Thirty to forty billion dollars spent on Part B Medicare is no less valuable to the American people than the 50 billion dollars we will spend on bailing out the Savings and Loan Associations. Additionally, money spent on medical care rarely adds to the trade deficit as it supports American services, research, and industry for the most part. "Can we afford health care?" is not really the question; it is "Do we choose to affort health care?"

Martin addresses quality assurance and outcomes research in his article. The American Urologic Association is committed to validating our implicit practice of urology by providing explicit guidelines and research in outcomes of urologic diseases. We do this not because we believe that such information will change the face of urologic care but rather to accept the challenge to our historically proven quality care and science. I believe that the cost of such research will bring marginal changes in urologic practice and will not be a justifiable expense. That Joseph Califano believes that more than 25%, or 200 billion dollars worth of what we do each year is of unverified effect at best and dangerous at worst is not surprising. As a participant in the creation of the "Great Society" he was told that Medicare was not affordable in the 60s. Now he wishes to educate us as why a 250 million dollar program has become a 250 billion dollar program. Senator Albert Gore (D-Tenn) concluded that significant savings could be obtained by not ordering unnecessary tests. He deduced that since 80% of the chest x-rays ordered were negative, they were unnecessary. Martin points to the Wennberg small area variation work as an example of inappropriate care. Practice referrals and access problems have as much to do with the variation in figures and are more likely an indicator of inadequate care as opposed to unnecessary care. Dr. Peter Albertsen of the University of Connecticut demonstrated that transurethral prostatectomy in Connecticut showed no significant variation. That probably reflects an even distribution of access to care while the data from Iowa, which does show variation, may reflect access problems in rural areas as well as variations in population expectations. In sum, data may be accurate, but the interpretation may be significanly skewed when one has a personal agenda.

In accepting Dr. Barkin's challenge to physicians to participate in all levels of government, might I suggest support, but also, care. We are entering an era of great change to say the least. We must participate as advisors, as well as become complete citizens by assuming roles in elected offices. Do not, however, be fooled by those who wish our presence to validate their policies. Having served as one of the campaign health policy task forces in this past Presidential compaign, I am well aware of the disdain many in government have for us because of our strong commitment to our current system and their budgetary difficulties.

The best method to assure health care that will provide Americans the quality needed is to strengthen our current pluralistic system. Government must assume its responsibility in funding the poor in a committed fashion. A basic, no frills benefit coverage package funded by employer—employee contributions will have to be enacted with protection for small business. It will be necessary to require those who choose no coverage and can afford to purchase the basic benefit package to in some way assume that responsibility. It will be necessary to fund the Medicare part B program of the future by developing a trust fund now and paying for those over 55 from the general fund until the program can be self sustaining. Funding our future now rather than borrowing form it to pay for the present is essential. Advocating these difficult self restraints on ourselves as a society will protect our future and that of our children. Only then will physicians return to their proper roles as statesmen in assuring quality, affordability, and accessiblilty to our health care system. ■

Gregory Slachta, M.D.

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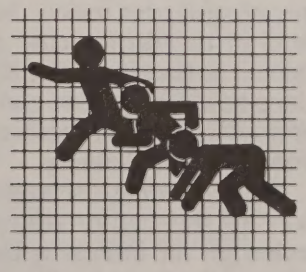

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"The National Practitioner Data Bank And Peer Review"

EDITOR'S NOTE: *Anita F. Sarro, is a lawyer with Bulkley, Richardson and Gelinas.*

Just two months ago on September 1, the final piece of a four-month old puzzle slipped into place. The piece is the National Practitioner Data Bank. The puzzle consists of the protections granted and the responsibilities imposed by the federal Health Care Quality Improvement Act of 1986.

The 1986 Act came into being largely as a result of the intense debate precipitated by a well-publicized case which pitted doctor against doctor. In *Patrick v. Burget,* the plaintiff-physician alleged (and proved to a jury) that his "colleagues," surgeons who had unsuccessfully tried to recruit Patrick to their competing practice, had taken numberous steps to harm his medical practice. The jury found that the defendants' actions, such as referring patients to physicians over 50 miles away rather than sending them to Patrick, were anticompetitive and so Patrick was able to prove his allegation that the defendants had violated federal antitrust laws. The plaintiff won a substantial verdict, and because professional liability insurance was not available to cover antitrust violations, the defendants were personally responsible for satisfying the judgment. But the reason the case received so much widespread attention is that some of the anticompetitive activity has occurred under the guise of hospital-based peer review.

The jury found that the defendant physicians had used their positions on various committees, including the medical staff credentialling committee, not for the purposes for which the committees were intended, but solely as a means to destroy the career of a colleague who had become their only local competition. It was this aspect of the case which made its way to the U.S. Supreme Court. The Court was asked to consider the relationship between professional review, so necessary to the improvement of the quality helath care, and antitrust theories, essential to the preservation of free market competition.

The Court recognized the importance of vigorous and meaningful peer review, but concluded, that under the facts of the *Patrick* case and in light of the law as it existed at that time, the actions of the defendant physicians taken within the context of hospital medical staff peer review committees were not automatically immune from antitrust liability.

The *Patrick* case served to focus well-deserved attention on the nature and process of professional peer review. In the intense debate which both preceded and followed the Supreme Court's decision, important policies and issues were discussed and clarified. It was recognized that there is a national interest in improving the quality of health care, and this interest would be well-served if practitioners were encouraged to vigorously undertake meaningful peer review. However, as the *Patrick* case illustrated, very often this essential function is being carried out by practitioners who are in competition with the physician whose professional activities were being reviewed. To help resolve this dilemma—the need to reinforce peer review while giving adequate protection to the process and its participants—resulted in the adoption of new federal law.

The 1986 Act seeks to encourage, strengthen and protect meaningful self-regulation of practitioners by practitioners. It does so in two ways: the provision of a statutory immunity from antitrust liability and the creation of the National Practitioner Data Bank.

In order to encourage meaningful peer review, the 1986 Act established an immunity from state and federal antitrust liability for participants in peer review activities undertaken by healthcare facilities' professional staffs, licensing boards, and professional societies. The immunity is available to all members and staff of a professional review body and witnesses and others providing information to it. The statute protects these individuals for liability arising out of peer review activities as long as the actions are taken on the basis of a physician's competence or professional conduct, in reasonable belief that the action is in furtherance of quality health care and is warranted by the facts, after reasonable efforts are made to obtain the facts and with adequate notice and an opportunity to be heard is extended to the physician.

The protection of this immunity has been available to participants of peer review for quite some time, but it is only recently that the second, important aspect of the legislation has become operational.

In order to make sure that the maximum nation wide benefit is derived from the results of peer review, the 1986 Act required the establishment of a National Practitioner Data Bank. This Bank has no other function except to serve as a repository of significant information concerning a practitioner's competence and conduct. It exists only to collect information provided by health care facilities, licensing boards, professional societies and professional liability insurers and to disseminate information only under specific, narrow circumstances. The Bank has no independent power of its own. It cannot make any decisions with respect to a practitioner's ability to practice. It has no other function except to receive information from mandatory reporters and to respond to appropriate inquiries.

The two main pieces of the 1986 Act are philosophically related: they both are in place to maximize the benefits derived by the public when the quality of health care is enhanced. They also are functionally related. Participants in a professional review activity who meet all the conditions mentioned above necessary to invoke the immunity from antitrust liability could lose that protection if the professional review action occurs in a facility or organization which is required to report to the Bank and fails to do so. It is therefore in the interest of all peer review participants to support the efforts of health

care facility and other organizations to comply with the reporting obligations imposed by the 1986 Act.

The requirements of the Bank have been well-publicized, both nationally and locally. Recent editions of publications such as the *American Medical News* have carried articles summarizing the basic components of the new system, the American Medical Association has published a booklet about the Bank, and some local health care facilities have begun in-service efforts to educate their practitioners to the requirements of the Bank. These resources are a much better source of complete information about the Bank than a short article such as this could be. But there are a few points worth stressing.

First, the reporting obligations of the federal law are in addition to, and not in place of, the reporting obligations now in place in Massachusetts. In the same year that the federal law was enacted, the Massachusetts legislature passed Chapter 351 of the Acts of 1986, otherwise known as the Medical Malpractice Reform Act. That legislation created a detailed set of obligations for health care facilities, insurers, and professional societies to report certain actions or events to the Board of Registration in Medicine. The purpose of the statewide reporting obligations is to make sure that the agency responsible for licensing physicians would have access to information that could call into question the physician's ability to practice medicine in this state. In this way, the licensing body could take action with respect to a physician's license if necessary to protect the public. In contrast, the reporting obligations of the federal legislation are intended only to permit the sharing across state lines of information which is pertinent to decisions regarding the licensure and credentialling of physicians. The Bank is not required or permitted to interpret the information it collects. The Massachusetts Board of Registration is obligated to do so.

Second, because the reasons for reporting are so different what is reported also varies. The definition of a "disciplinary action" reportable to the Board of Registration in Massachusetts is broader than the definition of the identical term under the federal law. Therefore, it is possible that an action by a peer review committee of a hospital medical staff may be reportable under Massachusetts law but not reportable under federal law. It will take some effort and patience to become comfortable with the distinctions.

Third, the federal system does not permit surprises. The Bank will not accept information for storage without first sending to the practitioner a print-out of the information supplied by the report in essentially the same form in which it will be available once finalized. The practitioner has 60 days in which to dispute the accuracy of the information in writing, but the Department of Health and Human Services (the agency responsible for administering the Bank) will not consider or resolve disagreements about the merits or the appropriateness of the action, only the accuracy of the information reported.

Fourth, every effort has been made to ensure that the information is kept confidential. Health care facilities and others must comply fully with the Bank's procedures and requests will be granted only if submitted on original forms available only from the Bank. Some concern has been expressed because under certain circumstances a plaintiff's attorney may have access to the Bank's information. But in order to do so, the attorney must jump through a series of procedural hoops. Moreover, if information is obtained, it cannot be used as evidence against the practitioner. The safeguards put in place should prevent inappropriate release and use of information.

Finally, any practitioner may take a self-inquiry. Inquiries must be submitted in writing on forms available from the Bank. The easiest way to request a form is to call the Bank Hotline at (800) 767-6732. The hotline staff also are available to answer any questions a practitioner may have about the Bank.

The creation of the National Practitioner Data Bank has been a slow process, but an important one. It presents the first opportunity for health care facilities, licensing bodies and their participants across the country to share meaningful information so that incompetent professionals cannot avoid the consequences of their actions merely by moving across state lines. It is a part of a continuing effort to improve the quality of health care by giving the maximum amount of information to the individuals in the best position to judge the adequacy of that care,—the practitioners themselves. ■

Artifical Intelligence in the Emergency Room

EDITOR'S NOTE: *John Holbrook, M.D., a specialist in Emergency Medicine, has been at the forefront of the Computer revolution applied to medical practice.*

The headlines in the December 8, 1989 "Wall Street Journal" stated "Computers Sharpening Emergency Room Skills!" The story described the "artifical intelligence" medical programs being developed at Mercy Hospital's (Springfield, MA) emergency department: one is a high technology record keeping system called "Voice EM™", the other, an automated quality assurance system, "ChartChecker™.

Voice-EM is a revolutionary software system developed by Kurzweil Applied Intelligence of Waltham, MA. It takes the human voice ("dictation" and converts it instantly into computer text ("the medical record") using a very sophisticated system of artificial intelligence software that "recognizes" the patterns of human speech. The system runs on a 386 PC computer. It takes the audio signal—the analog waveform—and converts it into a digital signal—a collection of numbers by statistically examining their mathematical properties. In 1988, the Mercy Hospital was one of the first sites in the country in which this technology was applied in emergency medicine.

Kurzweil Applied Intelligence's Voice-EM is one example of the exciting new field of ASR, or "automated speech recognition, speaker independence, and continuous speech recognition. The initial system at Mercy Hospital recognized only 1000 words. The systems currently in use in the emergency department now have functionally unlimited vocabularies. The initial system was "speaker dependent": that is, each new user had to "train" the whole vocabulary by saying each word four times. The current systems are "speaker independent": a new user can just pick up the microphone and have immedicate recognition. No one in the field has yet successfully crossed the last barrier of continuous versus discrete voice recognition. Thus, the current system will only recognize "discrete" words, so that a half-second pause is needed between each word. Continuous speech recognition is 1-3 years away. At that point, these systems will function like intelligent typewriters.

Because Voice-EM creates the report instantly on the screen, the physicians at Mercy Hospital were able to insert context—specific "prompts" or reminders at different spots throughout the creation of the medical report. These real time prompts initially focused on risk management and quality assurance. Subsequent applications have also focused on proper or optimized ICD-9 and CPT coding. The approach to quality assurance prompting for Voice-EM that was developed at Mercy Hospital is now deployed at over 150 emergency departments throughout the country.

Mercy Hospital now has four of these ASR workstations in its Ambulatory Care Department: two in the emergency department and two in Fast Track. They have been linked to each other on a LAN (local area network) so that the computers can talk to each other while the physicians talk to the computers. This is the first "voice activated" LAN of its kind in the country. Using this technology, the physicians can print the report the instant it is dictated. These reports can be transmitted electronically by FAX or modem; they are stored on disk for easy retrieval; they save the cost of medical transcription. In a study published in the April 1990 issue of *Annals of Emergency Medicine*, Dr. John Holbrook with Dr. Richard Aghababian from the University of Massachusetts Medical Center demonstrated the superiority of these records over hand-written records or records created by conventional dictation.

A second artifical intelligence system—called ChartChecker—has been developed and implemented at Mercy Hospital in conjunction with Voice-EM. ChartChecker "reads" any medical record created on a word processor and analyzes the logic, in a way similar to the "spell-checker" on word processors. ChartChecker's approach to medical logic is strictly empiric: it alerts physicians to diagnoses, omissions or patterns of logic that have been historically associated with succesful malpractice claims. These patterns of malpractice were assembled in a database by the Massachusetts Chapter of the American College of Emergency Physicians (MACEP.) The development of this database and the risk management program associated with it were reported in an article in the August 1990 issue of *Annals of Emergency Medicine* by Drs. Anita Karcz, Alan Davidson, and John Holbrook among others. ChartChecker has drawn on this database and other national closed-claims databases to do statistical analyses of physician's reporting behaviors for use as a learning tool to improve quality. ChartChecker will check thousands of charts in batch mode for aggregate analyses or can check each chart in "real time", as the chart is created and before the patient has left the emergency department.

Last year, MACEP filed for a malpractice rate reduction based on the use of the ChartChecker and a risk management training program develped by MACEP. A 20% malpractice rate reduction for qualified emergency physicians was granted by the Massachusetts Medical Malpractice Joint Underwriting Associations on February 8, 1990. A similar reduction has been granted for the use of the technology by two other national insurance companies, Physician National Risk Retention Group, and the Paradigm Insurance Co.

There are plans to expand this technology in the future at Mercy Hospital. The research group based there is collaborating with others throughout the country to develop an ASR application for outpatient surgery, and another for family medicine focusing on cancer prevention. ChartChecker is beginning development of an application to do automatic ICD-9 and DRG coding, and automated PRO review. ■

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Understanding And Reporting Disability

Disability claimants depend on medical providers to submit evidence of disability to advocates and appropriate agencies. Unfortunately, submitting evidence does not mean just dashing off a quick note that the patient cannot work. Forms may have to be filled out, detailed questions answered and copies of records provided. Physicians sometimes feel inundated with paperwork relating to possible disabling conditions. This article is designed to help physicians better understand disability standards and cope with disability claims paperwork.

Disability benefits usually are associated with one of three programs: Workers' Compensation, General Relief Assistance and Social Security or Supplemental Security Income (SSI) disability benefits. Each of these benefit programs may include health insurance. Employer's insurance is tied to Workers' Compensation; General Relief Medical Assistance is tied to General Relief Assistance; and Medicaid and Medicare benefits are tied to SSI and Social Security Benefits.

1. Worker's Compensation

Workers' Compensation is, as the name suggest, an insurance system designed to compensate workers who suffer from job-related accidents or disease. Compensation in the form of steady income is often only temporary and lasts only until the worker returns to work or reaches a maximum level of improvement, at which time the worker may receive a lump-sum settlement. The settlement is usually based on a rating of percentage of functional loss. Precise percentage tables are available and cover virtually all body parts. If disability is total, a worker may receive compensation for life.

The treating physician may be asked to provide evidence of medical condition, either through written records, affidavit, deposition or testimony. Insurers regularly have claimants examined by doctors who contract with the insurer. Plaintiff advocates may also choose doctors from preferred pools of specialists familiar with the rating system. However, treating physicians will still be called upon for opinions in many instances. Common questions are cause of illness, expected recovery time, prognosis, and percentage of functional loss. Except for rating functional loss, for which tables are available, answers are generally apparent from treating records. This is one reason why many physicians uncomfortable with other disability paperwork are relatively comfortable providing information for Worker's Compensation claims.

2. General Relief Assistance

General Relief Assistance (GR) is a state welfare program designed to provide a minimal income to persons unable to work because of disability. The standard for eligibility is low and requires no legal analysis, only a physician's conclusion that the claimant cannot work for at least 60 days.

Filling out GR forms is easy. Questions are brief and straightforward. Besides checking off boxes, the physician simply writes a short diagnosis, treatment and one-word prognosis. Physicians rarely complain of difficulty in filling out the form, only of the frequency with which they are asked to do so. The Department of Public Welfare requires claimants to be recertified as disabled every six months. Thus the physician with many GR patients may be called upon to fill out numerous forms. This can be time-consuming. One way to save time is by having support staff fill out the forms except for signature. This makes sense where the disabling condition is basically unchanged. Identifying patients entitled to other disability benefits is another time-saving measure. Patients who seem to meet the stricter criteria for SSI eligibility can be provided with medical evidence to support an SSI claim, for which recertification is usually unnecessary for at least three years.

3. Social Security and SSI

The Social Security Administration administers two benefits programs, Social Security benefits and SSI benefits. Both are based on either age or disability. They differ chiefly as to the source of funding. Social Security benefits consists of insurance benefits bought with the FICA tax. SSI benefits consists of supplementary benefits up to a specified income level when Social Security benefits and other income and assets fall short of the specified minimum. With few exceptions, the medical criteria for disability is the same under either program. Medicaid and Medicare also use the same criteria, Medicaid being based on financial need and Medicare being based on length of disability (two years). Thus providing evidence of disability can help patients receive the federal health insurance coverage to which they are entitled.

The Social Security Administration has contracted with Disability Determination Services (DDS) to determine whether claimants meet the medical criteria necessary for eligibility. DDS is a state agency attached to the Massachusetts Rehabilitation Commission. This agency regularly contacts physicians for medical records and answers to specific questions regarding specific diseases and their consequences. Disability advocates also contact doctors to update records and ask specific questions regarding symptoms, functional loss, etc. If claimants appeal denials of their claims, an Administrative Law Judge who hears the appeal may also request information from doctors.

The Social Security Administration recognizes only one type of disability: the inability to perform work that exists in substantial numbers in the national economy. Partial disability is not recognized. If a recipient is expected to improve, medical condition will be reviewed after a year or more.

continued

Understanding And Reporting Disability

continued

Once it is established that a claimant suffers from more than a very slight impairment and the impairment has lasted or can be expected to last at least one year or result in death, disability can be established for one of two reasons: (1) the impairment or combination of impairments meets or equals the strict criteria set by regulation (listed impairments), or (2) the claimant cannot return to past work and does not retain the functional capacity to transfer to other work in view of age, educational level and acquired work skills.

Listed impairments are impairments presumed to be disabling. They are classified according to body system and disease and contain criteria such as symptoms, prognosis, duration and standards for diagnosis. The physician shown a Listing should have little difficulty deciding whether the patient meets the Listing. Deciding whether a patient equals a Listing is more difficult. The physician must decide whether a patient's impairment or combination of impairments is as severe as the severity contemplated in the Listing. In other words, is the claimant as dysfunctional as a hypothetical person who would meet the Listing.

Some physicians are familiar with specific Listing in their fields of expertise but are unaware of other Listings in their fields. Still other physicians are familiar with all the Listings in their fields but unaware of the existence of any other criteria for medical eligibility. For instance, a pulmonary specialist may be aware of an asthma Listing based on pulmonary function testing but unaware of an asthma Listing based on frequency of hospitalization; an internist may be aware of an alcoholism Listing based on advanced liver damage but unaware of a Listing based on organic brain damage or an inability to control drinking; an orthopedic surgeon may be aware of Listing criteria for discogenic disease but unaware that workers with less severe back injuries may be disabled due to vocational factors and age. Such uninformed physicians sometimes make erroneous and damaging statements to the effect that a patient is not disabled. They would better serve their patients if they limited themselves to providing evidence of medical condition and functional capacity rather than stating conclusions about ineligibility.

Documentation of objective symptoms and signs can be crucial to disability claims. Symptoms and signs should include all symptoms, including those related to sequelae, side effects of medication, etc.

Opinion as to functional loss is often equally crucial. No tables measures functional loss. Rather, assessment of functional loss requires an individual determination based on all known impairments. A physician asked to assess function should attempt to specify functional ability rather than suggest a functional classification. A helpful assessment gives an opinion as to factors such as amount of weight that can be lifted, distance that can be walked, ability to take directions, etc. Such an assessment sheds light on overall functioning. But the physician who states that a patient cannot perform heavy work may only confuse the issue of functional ability. This is because such terms as "heavy" or "sedentary" are defined in Social Security regulations and a physician's use of these terms may not correlate with Social Security definitions.

DDS tries to provide forms that include questions about whatever specifics are needed to analyze a claim. Likewise, advocates ask specific questions geared to individual claimants. The physician who answers the questions asked and provides copies of records should not be overwhelmed with paperwork. Some physicians need not answer questionnaires if legible medical reports include answers to all questions. Often a physician will simply note "see attached" on questionnaires and substitute copies of reports for the questionnaries. A word of caution: all questions need to be answered.

A physician can also avoid time-consuming paperwork by calling DDS to dictate a telephone report or for follow-up to questionnaires. And a short call to an advocate may allow the advocate to reduce written questions to a bare minimum.

Physicians who want to help patients with claims can best serve them by cooperating with advocates and investigating agencies and providing the specific information requested. This is often the best way for a physician to "advocate" for a patient. Physicians can also help by indicating additional impairments not noted by a claimant. For example, a treating physician may alert DDS to a disabling mental condition. Typically, a patient claims disability due to "aching all over" or "arthritis" but the true disability is major depression with a somatoform disorder. Noting suspected depression on an arthritis questionnaire may be of as much value as any answer to the questionnaire itself.

Summary

Understanding different disability programs helps physicians cope with disability paperwork. This should result in more expeditious awards of benefits where appropriate. The physician saves time while promoting the interests of the patient,

NOTE: Any medical providers wishing to educate themselves about Social Security disability standards can write to me for copies of pertinent Social Security regulations. Regulations cover all body systems, physical as well as mental. Special rules apply for children and for alcohol and substance abuse. These will also be provided upon request. ■

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Dr. Cicely Saunders

With the above thought, Cicely Saunders, M.D., founded St. Christopher's Hospice in London in 1967, and with its founding the modern hospice movement was born. The concept of hospice originated in the Middle Ages when roadside care and lodging was provided for weary travelers. The term "hospice" referred to a warm, friendly resting place for those on a long journey. When religious orders began caring for the dying, the name was adopted because death was seen as the resting place in the journey of life.

St. Christopher's Hospice served as a model for the hospice movement in Northern Europe, Canada and the United States. Interest in the hospice movement was further fueled by the publication of the book, *On Death and Dying,* by Elizabeth Kubler-Ross, M.D. in 1969. The first hospice in the United States was started in 1974 in New Haven, Connecticut. The movement has grown rapidly, and currently the National Hospice Organization has identified more than 1700 hospice programs in the United States.

Hospice provides support and care for people in the final phase of a terminal disease and their families so they can live as fully and comfortably as possible. One of the goals of hospice care is to control pain and other symptoms and to help patients and family members deal with psychological issues and family concerns. The focus is on care and comfort rather than cure, and whenever possible care is provided in the patient's home and familiar surrounding. Emphasis is placed on enhancing and affirming the quality of life rather than on extending life.

Clinical Care

Hospice of Pioneer Valley, like most hospices, employs an interdisciplinary team approach to patient care. The team members coordinate their efforts on behalf of both the patient and the family and view the patient and the family as a unit. Attending physicians can feel confident in referring patients with a terminal ilness for hospice care as the physical, spiritual, and emotional needs of the patient/family unit will be addressed. In addition, attending physicians may retain management of the patient or elect to transfer medical management to the Hospice Medical Director.

The interdisciplinary team of Hospice of Pioneer Valley consists of a clinical nurse supervisor, registered nurses, and home health aides/homemakers; a medical social worker, a pastoral care giver, and a volunteer/bereavement coordinator. These operate under the direction of an executive director, who is responsible for administering the hospice program, and a medical director, who functions as advisor to the hospice team and who is available to consult with the family's physician or to assume medical management of the patient, if appropriate.

Hospice programs recognize that counseling and help in coping with grief, fear and anxiety are important

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Hospice: *Caring For The Terminally Ill*

continued

elements, as severe illness often exposes unresolved family problems. The hospice team works with families to help provide the services that will be most beneficial. Bereavement support groups are available to family members for up to a year after the death of their loved one.

Innovations in pain control have helped to carry out the hospice mission of palliative care and symtom control. In many hospices, adequate doses of narcotics around the clock are used to prevent rather than to treat pain. Continuous or intermittent parenteral narcotic use and patient-controlled analgesia are also growing in use.

Reimbursement

The Medicare hospice option became available in 1983. Patients must meet three criteria to be considered eligible. The patient's physician and hospice medical director certify that a patient has a life expectancy of six months or less. Election of the hospice benefit requires relinquising other Medicare benefits except reimbursement to the patient's attending physician; coverage for conditions other than terminal illness may continue. Finally, care must be provided by a hospice program certified by Medicare, which will provide medical and nursing care, home health services, inpatient care, social work, counseling, medications, medical supplies, durable medical equipment, and other services as needed.

Medicare pays the costs on a per diem basis for a total of 210 days. However, in keeping with Medicare regulations, certified programs must continue to treat patients who live past the 210-day limit. Some private insurance companies also reimburse hospice care on a per diem basis, but many negotiate on a fee-for-service basis. Medicaid also provides a hospice benefit similar to Medicare.

Hospice of Pioneer Valley

Hospice of Pioneer Valley (HPV) began providing Medicare certified hospice services to patients in August of 1988. The organization has cared for over 350 patients and their families in its two years of operation. Care is available 24 hours a day and Hospice of Pioneer Valley serves the communities of Agawam, Chicopee, East Longmeadow, Hampden, Holyoke, Longmeadow, Ludlow, Springfield, Southwick, Westfield, West Springfield, and Wilbraham.

Anyone may refer a patient to Hospice of Pioneer Valley. However, the individual and family must choose Hospice with the consent of the family and/or attending physician. If a patient decides to pursue new curative treatment, he or she may leave the program at any time.

Hospice of Pioneer Valley is particularly proud of the quality of services that it offers patients and their families. Hospice nurses are skilled in symptom management. They constitute a warm link between the patient/family unity and the physician by presenting well defined problems in a constructive way. In addition, Hospice nurses are certified to pronounce death. The entire Hospice team is committed to meeting the needs of patients and families and working with the attending physicians to ensure the finest possible care. ■

Willa J. Fasten,
Director of Marketing and
Communication
Hospice of Pioneer Valley, Inc.

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Welcome New Members

Maryann D. Lowen, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN:	April 11, 1945
PREMED:	Brown University 1963-1967 Yale University 1967-1968
MEDICAL:	New York Medical College 1974-1977
INTERNSHIP:	St. Vincent's Hospital and Medical Center 1977-1978
RESIDENCY:	St. Vincent's Hospital and Medical Center 1978-1980 (Internal Medicine) State University of New York 1985-1988 (Radiation Oncology)
FELLOWSHIP:	State University of New York 1980-1982 (Pulmonary)
SPECIALTY:	Internal Medicine/Pulmonary/Radiation Oncology

John V. O'Neill, M.D.
75 Springfield Road
Westfield, MA 01085

BORN:	November 3, 1943
PREMED:	Georgetown University 1965 St. Peter's College 1966
MEDICAL:	St. Louis University School of Medicine 1970
INTERNSHIP:	University of Connecticut Health Center 1970-1971
RESIDENCY:	Highland General Hospital, California 1973-1974 (General Surgery) University of Connecticut Health Center 1974-1977 (Otorhinoloarngology and Facial Plastic Surgery)
SPECIALTY:	Otolaryngology/Allergy/Immunology

Judith E. Tapper, M.D.
123 Dwight Road
Longmeadow, MA 01106

BORN:	July 26, 1961
PREMED:	University of Pennsylvania 1979-1983
MEDICAL:	University of Massachusetts Medical School 1983-1987
INTERNSHIP:	Baystate Medical Center 1987-1988
RESIDENCY:	Baystate Medical Center 1988-1990
SPECIALTY:	Pedicatrics

continued

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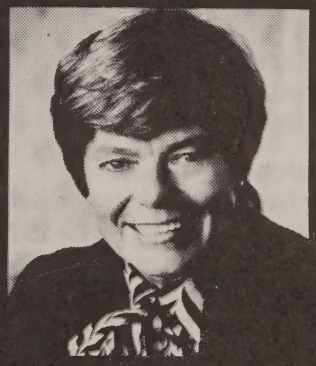

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Welcome New Members

continued from previous page

Jan B. Wojcik, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: January 19, 1958
PREMED: University of Massachusetts 1976-1979
MEDICAL: Tufts University School of Medicine 1980-1984
INTERNSHIP: St. Francis Hospital and Medical Center, Connecticut 1984-1985
RESIDENCY: St. Francis Hospital and Medical Center, Connecticut 1985-1989
FELLOWSHIP: St. Francis Hospital and Medical Center 1989-6/90 (Colon and Rectal Surgery)
SPECIALTY: Colon and Rectal Surgery

CORRECTIONS:

Robert D. Ficalora, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: July 8, 1956
PREMED: Fairfield University, Connecticut, 1974-1978
MEDICAL: State University of New York, Stonybrook 1978-1982
INTERNSHIP: Baystate Medical Center 1982-1983
RESIDENCY: Baystate Medical Center 1983-1985
SPECIALTY: Internal Medicine

Edward I. Galaid, M.D.
140 Carando Drive
Springfield, MA 01104

BORN: March 28, 1953
PREMED: University of Massachusetts 1971-1973
Clark University 1973-1975
MEDICAL: Columbia University 1975-1977 (Master of Public Health)
State University of New York—Downstate 1979-1983 (Medical Degree)
INTERNSHIP: Temple University Hospital, Pennsylvania 1983-1984 (Categorical Medicine)
RESIDENCY: University of Kentucky Medical Center 1984-1986 (Preventive/Occupational Medicine) Baystate Medical Center 1986-1988 (Internal Medicine) Center for Disease Control 1988-1990
SPECIALTY: Occupational Medicine/Internal Medicine

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STREET: _____

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TELEPHONE: _____

The Doctor Max and Ida L. Millman Foundation and the HDMS Scholarship Fund

In June, 1976, shortly after the sudden and unexpected death of Dr. Max Millman, at that time Editor of the Hampden Hippocrat, and at the instigation of Mrs. Max Millman, the Society established the scholarship fund as a tribute to the late Dr. Millman. Dr. Millman was a prominent Internist and pioneer Cardiologist beloved and respected by his colleagues and patients.

Contributions to the fund were received from his many friends and colleagues both in the community and in the Hampden District Medical Society. His wife, Ida L. Millman, contributed $25,000.00 to the fund, the interest of which was to be used for the annual scholarships awarded to applicants in medical school from Hampden County. Generous contributions are at the present time received from Mrs. Millman's sister and brother-in-law, Mr. and Mrs. Sydney Freedman. Contributions to the fund can be used for memorials and in celebration of events by calling the district society office. The Executive Secretary will send a "thank you" card to the donor and an acknowledgement of the contribution to the persons being honored or to the family of the person being memorialized.

The requirements for consideration for a scholarship are monetary need to pay for tuition and expenses after admission to an approved medical school. Eligibility, in addition to monetary need, is scholastic performance in college plus grades for those already in medical school, without regard to sex, race, creed or national origin. A certifying statement from the college or medical school must accompany the application. The deadline for submission of a completed application with all the necessary information and school certification is September 1st of that calendar year.

The accompanying table indicates the numbers of awarded scholarships each year and the range of dollars available. Where there were many applicants and inadequate funds available, the deserving students received smaller amounts, sharing the total amount of dollars available. The committee felt that since large numbers of applicants were worthy of funding, it was difficult to turn down those who were deemed eligible. In the past fourteen years, $44,891.00 has been distributed to 109 students. Contributions of $2,000.00 a year were received from Massachusetts Medical Society and $4,500.00 from Hampden District Medical Society. Approximately $4,000.00 a year in earned interest is available from the Millman Foundation. Whereas the scholarship monies from Mass. Medical Society and Hampden District Medical Society are outright gifts, the scholarships from the Millman Foundation are loans to be repaid five years after completion of the recipient's training program. It was hoped that by receiving such funds back, the scholarship program could make grants in larger amounts to more students. Interest would then increase in amounts required to build up our fund. It is to be noted that the allocation of funds has come from interest and that the capital fund is never disturbed. At the present time the capital fund is approximately $34,000.00 and safely invested at a reasonable interest.

YEAR	NUMBER OF STUDENTS	AMOUNT AWARDED
1977	3	$1,500.00
1978	7	2,500.00
1979	5	2,000.00
1980	11	3,700.00
1981	12	4,050.00
1982	15	4,950.00
1983	15	4,995.00
1984	17	3,196.00
1985	5	2,750.00
1986	5	3,250.00
1987	5	4,000.00
1988	5	4,000.00
1989	4	4,000.00
TOTAL	109 STUDENTS	$44,891.00

Applications for residents of Hampden County are available by calling or writing to Mrs. Nystrom at the District Office, 1111 Elm Street, West Springfield, MA 01089, (413) 736-0661. ■

Submitted by,
Bernard Bloom, M.D.
William Coen, M.D.
Scholarship Committee Chairmen

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Community 2000 Responds To AIDS: *A Lesson In Grassroots Organization*

So what can a local grass roots coalition do for a group of Hampden County physicians? According to the 200+ member Community 2000 Hampden County AIDS coalition, it can serve as a resource to providers and care givers throughout the county by coordinating services, planning programs, providing support, and developing resources.

Responding to a need for an effective networking system among area service providers, the AIDS coalition has printed, thanks to Monarch Capital Corporation, 1500 copies of the *AIDS Resource Manual.* The 100 page directory provides needed information about available AIDS services throughout Hampden County and makes this information available to people affected by HIV, to their families and loved ones, and to their providers. Over eighty local agencies are included, and the manual will be updated as needed. For more information on how to receive a copy, contact Lisa Hargreaves at (413) 784-6036.

In response to a need for more primary care physicians who are willing and trained to treat HIV infected individuals, the Coalition has set up a physician education course for this November. As the number of HIV infected individuals continues to rise, primary care physicians, practicing at the community level, increasingly will be looked to for the provision of quality care. Sponsored by the Infectious Disease Division at Baystate Medical Center and the Berkshire Area Health education Center, in cooperation with the New England AIDS Education and Training Center, the 3-session course will offer both didactic information and hands-on clinical experience. The course will teach primary care providers the basic skills and knowledge they need in order to deliver HIV testing and counseling, medical management, and ongoing care for people with AIDS and HIV infection. There is no fee for this program, and space is limited. Seven category 1 credits will be awarded to physicians. For more information about the course, contact Joanna Ezinga at (413) 447-2417.

As the Coalition identifies service deficiencies, unmet needs, and barriers to available AIDS services in Hampden County, input from local physicians is greatly needed. The Coalition invites each member of the medical community to become involved in helping it address issues of AIDS in Western Massachusetts.

To learn more about the programs of Community 2000 and the Hampden County AIDS coalition, contact Lisa Hargreaves, M.Ed. Coordinator, at (413) 784-6036. ■

Lisa Hargreaves, M.Ed., Coordinator
Community 2000 Hampden County
AIDS Coalition

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Quitters Are Winners

EDITOR'S NOTE: *Timothy Jones, the Project Coordinator for the Springfield Quits Smoking Project, submitted the following information.*

A protocol for a study on the primary prevention of cancer (smoking) in black adult populations is being conducted by the Division of Public Health School of Health Sciences at the University of Massachusetts in cooperation with sites in South Carolina, North Carolina, and Connecticut.

Although there has been some modest improvement in morbidity and mortality due to cancer during the last decade, one exception is that there has been no reduction of cancer mortality or morbidity among black Americans, whose rates remain the highest of all racial groups in the U.S.

This study is directed at the need to reduce the rate of smoking among black populations, and has the goal of developing a smoking intervention program for use in black communities.

The program consists of a passive and an active component. The passive component consists of a mass-media approach. The active component applies principles of community organization to establish an advisory committee, a network of community health advocates, a professional advisory committee, and focus groups in the community.

The relative effects of the active and passive intervention strategies on middle income and lower income communities will be analyzed, as well as the impact of geographic differences.

A baseline study conducted from October 1989 through June 1990 tested the prevalence rate of smoking, smoking histories, and demographic characteristics.

5750 dwelling units were identified in the target area (Mason Square Community.)

4296 units were located.

A total of 3660 dwelling units were contacted. 961 screening interviews, 672 smoking histories, and 429 key interviews were completed.

One of three households were "smoking" households, averaging 1.3 smokers per household.

15 cigarettes per day (273 packs per year) is the average smoked per person. (The Massachusetts' average is 117 packs per person per year.)

4/5 of smokers said they wanted to quit; 1/2 said they tried to quit; 4/10 felt that they would not be smoking one year from now.

85% were unaware of any smoking cessation programs in Springfield.

53% had not been told to quit smoking by their health care provider.

Affordable smoking cessation workshops have been sponsored by the Springfield Quit Smoking Project at various locations. The pilot workshop ran from June 18 through August 6, 1990. Two other community based workshops were begun in September. A fourth workshop will be scheduled soon.

Physicians and others who are interested in more information about the Springfield Quit Smoking Project can contact the office at 739-7511 between 9:00 a.m. and 5:00 p.m. Monday through Friday, or they can visit, no appointments necessary (622 State Street, Room 38, Springfield, MA 01109). ■

IN MEMORIAM

JOSEPH T. BAGAMARY, JR., M.D., passed away September 24. He was a family practitioner in Westfield. He was Chief of Medicine at Noble Hospital, and served on the executive committee of the Hampden District Medical Society.

Contributions in his memory should be made to The United Cerebral Palsy Fund. ■

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Alzheimer Respite Volunteer Program

The visiting Nurse Association of Pioneer Valley is sponsoring a respite program for care givers of Alzheimer's Disease patients. The respite volunteer is an informed, caring individual who under the supervision of VNAPV personnel, offers planned, temporary respite for family caregivers. The objectives of the program are:

1. To offer families dealing with Alzheimer's disease or a related disorder an opportunity to regain perspective, composure and humor through planned temporary periods away from patient care.
2. To provide companionship to patients and families.
3. To assist the family in maintaining the Alzheimer patient in home-based family care.

The respite volunteer is expected to:

1. Attend a training series tailored to his/her needs and experiences.
2. Be a caring and responsible friend to the family/patient unit.
3. Attend a monthly educational/support meeting.
4. Keep written records of visits.

Further information is available from Patricia Hays, Alzheimer Respite Volunteer Coordinator. She may be contacted through the VNA of Pioneer Valley, P.O. Box 516, Springfield, MA 01151-0516, or at 781-5070. ■

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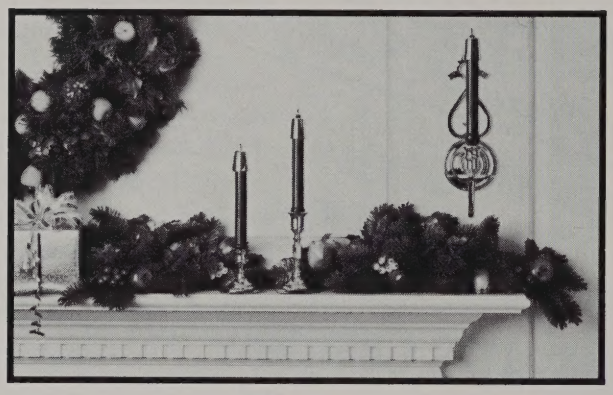

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